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Evaluation of Immunization Status of a Community's Year-Old Children*

INTRODUCTION

Immunization is one of the principal procedures used in the control of certain communicable diseases, so a large number of immunizations are being done continually by private physicians and through official agencies. A substantial decrease in the incidence of some of these diseases has been noted during recent years and this is usually attributed to keeping the level of immunization high. If critical indices of the level of immunization in a given community are available to the health officer, he can administer preventive programs intelligently and be assured that the proportion of immunized population is at a level that will protect the community from an epidemic.

To determine such indices, information is needed regarding the number and kind of immunizations, the ages at which immunizations are done, and age composition of the population within the community. Adequate information of this type is hard to gain and there are few documented studies in the medical literature recording methods used for gaining such information and the results of their use.

NEEDS AND OBJECTIVES

The need for a method or methods for evaluating the immunization level of the population of a given community, has been recognized for some time by local

health officers in California. Through the Conference of Local Health Officers, they requested that the State Department of Public Health draw up a sampling technique that might be used by a local health department to evaluate the level of immunization of infants and children in its jurisdiction. The primary objective would be to determine the percentage of children of a given age group who have been immunized against diphtheria, pertussis, tetanus and smallpox.

A committee * was formed for this purpose within the State Department of Public Health. As a starting point, the committee believed it was logical to work out methods and procedures which might be used to determine the immunization level in one specific age group in a population. They chose the one-year-old children. They also made certain basic assumptions and definitions.†

METHODS OF COLLECTING DATA

It soon became obvious that no single method or procedure is likely to be equally adaptable to all areas of the State. Differences in population composition, size of area involved, local health department organization and size of staff make it necessary to "tailor-make" the procedure to fit the particular situation

† Suggested Assumptions and Definitions

- a. That a child who had received a series of injections could be assumed to have had triple vaccine D. P. T. This is believed to be a valid assumption because of present day practice and the fact that triple vaccine is the preparation produced by most houses making biologics.
- b. That a child who has been vaccinated for smallpox may be considered to be immune. This assumption is necessary unless there is provision for personal visits to each child or some other device to obtain evidence of a satisfactory "take."
- c. That the procedures covered in the survey could be limited to triple vaccine (D. P. T.) and smallpox vaccination. This follows the recommendation of the Conference of Local Health Officers.

* Condensation of a report, "A Study of Methods for the Evaluation of Immunization Status of the One-year-old Children in a Community," prepared at the request of the California Conference of Local Health Officers by a committee of staff of the State Department of Public Health composed of: Charlotte Singer-Brooks, M.D., Bureau of Maternal and Child Health; Geraldine B. Edwards and Robert M. Drake, M.D., Bureau of Acute Communicable Disease; Florence Olson and Arline Lewis, Bureau of Records and Statistics; and John R. Philp, M.D., Division of Local Health Service.

which exists in each health jurisdiction. Feasible methods of collecting data for this purpose include:

1. A survey of a predetermined sample of houses by district or of all houses in a district.
2. Use of birth certificates for selection of parents to be contacted.
3. Use of a questionnaire sent through school-age siblings to parents of infants.
4. Use of a questionnaire sent to all homeowners.
5. Use of records of practicing physicians and of records of well-child conferences.
6. Combination of any of the above.

The procedures necessary for each and the advantages and limitations of each must be considered before deciding upon any one method or a combination of methods to be used.

PREPLANNING

But even before making a decision upon the method, the health officer must first make certain assumptions and decide upon definitions † and also recognize that he has considerable preplanning to do. Such questions must be answered as: Is this study to determine immunization level only or is there interest in motivating parents to have children immunized? Is it desirable to collect other information such as that on prenatal care at the same time? How will such information be used? Is this a one-time study or is it to be integrated into long-range plans for routine follow-up which may include another survey on immunization status? If there is to be presurvey publicity, then how much and what kind of publicity is desirable and how much money is available for publicity?

Another important consideration is how much staff personnel and time can be used for the study. Both the initial attempt to get the information and follow-up should be taken into account. In some cases, volunteer workers can be utilized. Many other factors come into the preplanning picture such as: the time of year best suited for the study in terms of available staff, weather conditions, and population movement; the area or areas to be covered; how people are to be contacted—whether by mail, by visits to the home or otherwise, and how much follow-up will be necessary to attain the desired completeness of coverage.

PROCEDURES

Regardless of the method or methods for collecting data that are to be used, certain procedures are necessary if valid data are to be obtained. If only a sample of households are to be surveyed or a sample of birth certificates used for selecting parents to be contacted, standard sampling procedures should be used in choos-

ing such a sample. Questionnaires or record forms including any that are to be used for follow-up and instructions must be designed, office procedures for handling the records and summarizing the data be planned and a specific person be given the responsibility for analyzing and interpreting the data. Procedures for follow-up will need to be decided upon also.

If the method chosen involves the use of personnel or records of schools or private physicians, procedures which involve the schools or physicians will have to be worked out with them.

ADVANTAGES AND LIMITATIONS

Each method has certain advantages and also has some limitations.

A survey of a predetermined sample of houses by district would give a nearly complete picture of the one-year-olds in the group surveyed. If the sample chosen is representative of the entire area, the results may be interpreted as applying to the whole area. But such a survey may involve too much staff and time to be practical and is not as applicable for widely scattered farm dwellings as for homes in urban or suburban areas.

If birth certificates are used for selecting parents to be contacted, these basic records should be readily available in the health department. For all infants born in the area, a birth certificate is filed with the local health department and for births of residents occurring outside the area, a copy of the certificate is sent to the local department. However, no certificates will be available for those children who have moved into the area after birth. If questionnaires are mailed to parents on the basis of the information given on birth certificate, returns with information will probably not exceed 60 percent even with preparation of the public. The interpretation of results based upon these incomplete returns cannot be applied to the entire group of one-year-olds.

Questionnaires sent to parents of infants through school-age siblings would have the advantage of including one-year-olds who have moved into the area after birth, but would automatically exclude all first-born infants and others who do not have siblings of the particular school-age group chosen to work through. In 1951, about 33 percent of the live births in California were first children. Other advantages of this method are that it is relatively inexpensive and simple and that the school mechanism for obtaining information usually brings good results. This method could be used to good advantage in combination with some other method or methods.

If questionnaires are sent to homeowners, a supposedly more stable population would be reached, but a large group of non-homeowners would be missed.

The use of records of practicing physicians plus the records of well-child conferences would be applicable only in small areas where a few physicians do all the immunizations. However, the accessibility of records might be a problem so that this method could give a very incomplete and also a biased sample of one-year-olds.

Since there is a scarcity of information on results of studies done by any of these methods, it is hoped that when studies are done by any method, or combination of methods, that the information will be made available to others who may be interested. Perhaps no two areas can use exactly the same procedure since the situation, time, and personnel vary considerably, but the experience in one area would be useful in planning for another area.

Further detail on procedures, advantages, and limitations of the methods have been outlined for the Study Committee on Maternal and Child Health and accepted by the Conference of Local Health Officers. These outlines are available from the Division of Local Health Service, State Department of Public Health, if anyone wishes further information.

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Transfer of Dr. Shepard to New York Announced by Metropolitan

Dr. William P. Shepard, Third Vice President of the Metropolitan Life Insurance Company in charge of the Health and Welfare Division for the Pacific Coast Office since 1926, will transfer on October 1st to Metropolitan's New York office. In announcing the transfer, his company stated that Dr. Shepard is to be in charge of Metropolitan's entire health and welfare program, effective January 1, 1954.

For several years Dr. Shepard has served as a consultant to the State Department of Public Health in health education and industrial health, and has held important offices in numerous public health organizations. In 1950 he was President of the American Public Health Association and from 1939 to 1949 he was Chairman of the APHA Committee on Professional Education. He was Secretary of the Western Branch, APHA, from 1928 to 1939, and president of that organization in 1940-41.

Early in his public health career, 1925-26, Dr. Shepard served as health officer for the City of Berkeley. His broad interests in public health led him to the presidency of the California Tuberculosis and Health Association in 1943-44, and of the National Tuberculosis Association in 1946-47. He served as president of the San Francisco Social Hygiene Association in 1947-48, and held membership in the Northern California Public Health Association, an affiliate of APHA, and the California Heart Association.

He has held many assignments of national significance, among them membership on the Health Resources Advisory Committee of the Office of Defense Mobilization.

Friends in the Bay area held a dinner in his honor at the Olympic Club September 24th.

The usual cooperative service of Metropolitan's Health and Welfare Division in the Pacific Coast Head Office will continue as before under the direction of Dr. Earle T. Dewey, Assistant Medical Director.

OCCUPATIONAL DISEASES IN CALIFORNIA, 1952

During 1952 reported cases of occupational diseases totaled 20,482. Thirty percent of these resulted in absence from work beyond the day of injury, 59 percent caused no lost time, and in 11 percent it could not be determined from the report whether or not lost time occurred.

Diseases of the skin accounted for 50 percent of all the cases reported. Of these skin-disease cases, 46 percent were caused by oils, gases, solvents, and chemicals, and 38 percent were due to poison oak. Poisoning by venom (mainly insect bites and stings) accounted for 10 percent of all the cases reported, diseases of the bones and organs of movement for 15 percent, and diseases of the eye (mainly welding flash burns) were responsible for 12 percent of the total. Systemic effects of industrial poison resulted in 3 percent of the cases. Included in 3 percent of more serious conditions were 48 cases due to industrial solvents, 71 due to lead, 19 due to other metals, 63 due to carbon monoxide, 241 due to other gases, and 177 due to agricultural chemicals. Eighteen cases of pneumoconiosis were reported.

Workers in manufacturing accounted for 41 percent of the total number of cases of occupational diseases reported during 1952, while agricultural workers and construction workers each accounted for 13 percent of the total, and government workers for 10 percent.

Occupational diseases were reported from all counties except Alpine. The four counties reporting the greatest number of cases were Los Angeles County with 38 percent of the total, San Francisco and Alameda Counties each with 5 percent of the total, and Santa Clara County with 4 percent.

Occupational disease fatality reports were obtained from several sources. Data on deaths from silicotuberculosis were obtained from the Department of Public Health vital statistics records. The sources of the remainder of the deaths included in the tabulation are the fatal cases reported to the Department of Industrial Relations and the claims brought before the Industrial Accident Commission. The latter relate to the year in which a settlement was made and not necessarily to the year of death. It should be noted that prior to 1951, the fatalities included were only those for which death benefits were awarded by the Industrial Accident Commission during the year. However, since 1951 the tabulations also include deaths for which compromise and release settlements were approved by the commission. Fatalities reported from all these sources numbered 212. Of these 58 percent were due to diseases of the heart and 22 percent due to silicosis.

Every employer of a worker who sustains an industrial injury and every physician in California who attends an injured employee covered by the State Workmen's Compensation Act is required under Section 6407 of the Labor Code to file a report of the injury with the Department of Industrial Relations.

The Division of Labor Statistics and Research of the Department of Industrial Relations prepares statistics and reports on all disabling work injuries. The Bureau of Adult Health of the Department of Public Health, in accordance with an inter-agency agreement, reviews and analyzes doctors' reports which cover occupational diseases. The number of these reports processed by the Bureau of Adult Health increased considerably during the latter half of 1951 and 1952. While some of this increase was a result of increased employment, the major factor was an improvement in the procedure for obtaining the occupational disease reports, instituted in July of 1951, following consultations with the Department of Industrial Relations.

The use of these reports is a valuable aid in evaluating the occupational health problem in the State and in determining those areas and those industries which have the greatest need for preventive health services. However, this statistical analysis is subject to several limitations. The California Workmen's Compensation Act does not cover certain groups of workers such as self-employed workers, federal employees, maritime workers, railroad workers in interstate commerce, and workers employed by farmers who elect not to be covered. Also only a first report is now required. This covers the preliminary findings made by the physician and does not in all cases reflect the final diagnosis. Furthermore, only the estimated amount of lost time can be given, which results in some margin of error concerning the length of disability.

Dr. Poole on Foreign Assignment

Dr. Belle Dale Poole, Child Health Consultant with the State Department of Public Health, has taken a year's leave of absence to accept a position as Professor of Maternal and Child Health with the Department of Preventive Medicine and Public Health of the American University at Beirut, Lebanon. The position was established by the Technical Cooperation Administration under the "Point Four" program.

Dr. Poole has been with the State Department of Public Health since 1947, with headquarters in Los Angeles.

TABLE 1
REPORTED CASES OF OCCUPATIONAL DISEASES¹ BY DISEASE GROUP AND MAJOR INDUSTRY GROUP
CALIFORNIA, 1952

Disease group	Total	Industry group									
		Agriculture	Mining and quarrying	Construction	Manufacturing	Transportation, communication and utilities	Trade	Finance, insurance, and real estate	Service	Government	Not stated
Total, all diseases	20,482	2,516	129	2,395	8,431	956	1,144	158	1,354	1,968	1,431
Infective and parasitic diseases, total	208	7	1	4	75	2	16	1	27	75	-
Tuberculosis	27	-	-	1	1	-	-	-	3	22	-
Brucellosis	2	-	-	-	1	-	-	-	-	1	-
Anthrax	-	-	-	-	-	-	-	-	-	-	-
Other infective and parasitic diseases	179	7	1	3	73	2	16	1	24	52	-
Diseases of the eye, total	2,401	64	37	407	1,311	82	26	6	107	47	314
Conjunctivitis and ophthalmia due to welding flash	2,351	64	37	395	1,295	82	19	6	99	44	310
Other conjunctivitis and ophthalmia	49	-	12	16	-	-	7	8	2	4	-
Other	1	-	-	-	-	-	-	-	1	-	-
Diseases of the ear	57	-	-	3	14	36	-	1	1	1	1
Diseases of the central nervous system and peripheral nerves	132	8	-	8	80	7	13	3	6	-	7
Diseases of blood and blood-forming organs	6	-	-	-	3	-	1	-	2	-	-
Diseases of the respiratory system, total	613	48	10	55	321	10	21	3	43	64	38
Acute upper respiratory infection	189	11	2	12	119	5	6	2	16	8	8
Influenza, pneumonia, bronchitis	295	31	5	33	132	4	8	1	22	43	16
Silicosis and other pneumoconiosis	18	2	-	2	12	-	-	-	-	-	4
Other and unspecified diseases of the respiratory system	111	6	1	10	58	1	7	-	5	13	10
Diseases of the skin, total	10,388	1,371	36	1,251	3,898	543	656	70	662	1,292	609
Occupational dermatitis due to oils, greases, solvents and chemicals	4,803	255	12	352	2,696	96	493	37	375	150	337
Occupational dermatitis due to poison oak	3,955	690	21	832	447	412	29	28	202	1,082	212
Other diseases of the skin	1,630	426	3	67	755	35	134	5	85	60	60
Diseases of the bones and organs of movement, total	3,016	228	4	287	1,653	85	228	45	201	78	207
Synovitis, bursitis and tenosynovitis	2,559	210	4	259	1,397	70	186	28	168	71	166
Other diseases of the bones and organs of movement	457	18	-	28	256	15	42	17	33	7	41
Systemic effects of poisons, total	630	140	19	29	253	11	15	3	45	77	38
Poisoning by industrial solvents	48	-	-	1	30	-	1	-	9	2	5
Poisoning by lead and its compounds	71	1	5	5	52	1	2	-	1	1	3
Poisoning by other metals	19	-	-	1	13	-	2	-	1	-	2
Poisoning by carbon monoxide	63	5	1	10	32	1	2	-	-	3	9
Poisoning by other gases and vapors	241	12	13	11	101	8	4	2	12	68	10
Poisoning by pesticides and other agricultural chemicals	177	122	-	-	20	1	4	1	20	3	6
Poisoning by other industrial compounds	11	-	-	1	5	-	-	-	2	-	3
Poisoning by venom ²	2,022	536	13	208	495	126	117	17	133	217	160
Effects of weather, exposure and related conditions, total	200	50	2	37	56	8	7	4	9	16	11
Effects of heat and insolation	178	46	1	37	49	7	6	4	8	9	11
Other effects	22	4	1	-	7	1	1	-	1	7	-
Burns, total	330	22	4	82	137	15	15	4	21	7	23
Burns, chemical ³	328	22	4	82	135	15	15	4	21	7	23
Friction, X-ray and other burns	2	-	-	-	2	-	-	-	-	-	-
Neoplasms, total	5	-	-	-	2	-	-	-	1	-	2
Malignant	-	-	-	-	-	-	-	-	1	-	2
Benign	5	-	-	-	2	-	-	-	-	-	-
Allergic disorders	95	12	-	9	50	4	7	-	6	3	4
Diseases of the circulatory system	151	11	2	7	38	10	11	1	10	51	10
Diseases of the digestive and genito-urinary system	42	5	1	5	9	5	1	-	14	-	2
Symptoms referable to systems or organs and ill-defined conditions	31	2	-	1	11	2	2	-	8	4	1
Prophylactic treatment and medical examination without sickness	149	11	-	2	23	10	6	-	58	36	3
Not specified	6	1	-	-	2	-	2	-	-	-	1

¹ Diseases attributable to occupational exposure. Excludes diseases of employees not covered by the California Workmen's Compensation Act, such as self-employed, federal employees, maritime workers, railroad workers in interstate commerce, and workers employed by farmers who elect not to be covered.

² These are mainly effects of insect bites or stings.

³ These consist only of burns arising from repeated exposures. Burns from heat, fires or explosions are reported in the accident statistics of the Department of Industrial Relations.

SOURCE: State of California, Department of Industrial Relations, Doctor's First Report of Work Injury. Statistics compiled by State Department of Public Health, Bureau of Adult Health.

TABLE 2
FATALITIES ATTRIBUTED TO OCCUPATIONAL DISEASES¹
CALIFORNIA, 1952²

Disease	Number of fatalities	Disease	Number of fatalities	Disease	Number of fatalities
Total.....	212	Infective diseases—Continued		Effects of exposure, total.....	7
Diseases of the heart.....	124	Tetanus.....	5	Cold.....	1
Silicosis, total.....	46	Tuberculosis.....	2	Heat.....	6
Silicosis.....	12	Poisonings, total.....	16	Malignant neoplasms.....	2
Silicotuberculosis.....	34	Anoxemia.....	1	Cerebral hemorrhage.....	1
Infective diseases, total.....	9	Benzine fumes.....	1	Miscellaneous.....	7
Encephalitis.....	1	Carbon monoxide.....	2		
Pneumonia.....	1	Carbon tetrachloride.....	5		
		Chlorine gas.....	1		
		Methylbromide.....	1		
		Styrene gas.....	2		
		Gases, unspecified.....	3		

¹ With the exception of silicotuberculosis, these reports represent death benefits awarded or compromise and release settlements approved by the Industrial Accident Commission in 1952 for persons covered by the State Workmen's Compensation Act.

² Data on deaths from silicotuberculosis are obtained from the State Department of Public Health records and are deaths occurring in 1952. Data on other fatalities relate to the year in which the Industrial Accident Commission decision was made and not to the year of death.

SOURCE: State of California, Department of Industrial Relations, Reports of Fatalities. Statistics compiled by State Department of Public Health, Bureau of Adult Health.

Health Officer Changes

Humboldt-Del Norte Bicounty Health Department, and Monterey County

Resignation of Dr. Kenneth Sheriff, Monterey County Health Officer, to enter private practice in Santa Clara County, has resulted in a second shift in local health officers. Dr. Myron W. Husband, Health Officer of the Humboldt-Del Norte Health Department for the past four and one-half years, has resigned to become the new health officer for Monterey County. The change is effective October 1st. To replace Dr. Husband, appointment has been made of Dr. John A. Carswell as the new health officer for Humboldt-Del Norte Counties. Dr. Carswell returns to California from his position as Deputy Commissioner of Health for the Alaska Department of Health. He was formerly Santa Barbara County Health Officer (1942).

Modoc County

Dr. Paul Allen Wright was appointed Modoc County Health Officer effective September 1, succeeding Dr. J. Paul McKenney.

Santa Barbara County

Dr. Joseph Nardo, Santa Barbara County Health Officer, is taking a leave of absence to attend Columbia University, where he will complete a Masters Degree in Public Health. In his absence Dr. Lauren F. Busby, chief of that department's tuberculosis service, will serve as deputy health officer.

Vital Registration Institute Held in Six Cities by S. D. P. H.

The Bureau of Records and Statistics of the California State Department of Public Health held a Regional Institute on Vital Registration for statistical personnel from local health departments during the early part of September, 1953. Meetings lasting one to two days were held in six cities scattered throughout the State (Fresno, Long Beach, Riverside, Salinas, Berkeley, Sacramento) with an average of 15 persons from surrounding health departments attending each of the meetings.

The first half of each meeting was spent in discussing "New Vital Registration Legislation," "Improving Accuracy, Editing and Querying for Completeness

San Bernardino County Dedicates New Health Building

The San Bernardino County Health Department recently dedicated their new building at 340 Mt. View Avenue, San Bernardino. The spacious new structure embodies advanced design for practical housing of the modern health department. This is the latest in a series of new health department buildings that have been erected recently by California communities to provide adequate space and facilities for their health department activities.

These new department buildings have been financed by various combinations of local, state and federal funds. In the case of the San Bernardino Health Department, Hill-Burton funds (federal) were not used; the construction was financed by local funds and State Public Health Assistance funds.

Dr. Merle Cosand, San Bernardino County Health Officer, and his staff moved from their old quarters in the courthouse to the new building early in August, but the formal dedication did not take place until August 26th. The ceremonies were conducted by the Native Sons of the Golden West and attended by large numbers of San Bernardino residents. Dr. John C. Dement, Chief of the Division of Local Health Services, represented Dr. Wilton L. Halverson, State Director of Public Health, who was unable to attend.

of Certificates" and "Relationships Between Local Registrars and Reporting Agencies." The rest of each meeting took up the specific questions and problems submitted in writing by the local health department staff attending.

These small meetings represent a departure from the usual institute pattern and are an attempt to make discussion easier for participants.

YOLO COUNTY SURVEY: A SUMMARY REPORT

HERBERT BAUER, M. D., M. P. H., Yolo County Health Officer and
ROBERT L. NEWTON, President, Yolo County Tuberculosis and Health Association

With the help of the United States Public Health Service, the Yolo County Tuberculosis and Health Association, the State Department of Public Health, and the State Tuberculosis and Health Association, a community-wide chest X-ray and diabetes survey was undertaken in Yolo County in March and April of this year.

The sponsoring agencies in Yolo County were: Health Department, Tuberculosis and Health Association, Medical Society, Heart Association, Cancer Society, and Red Cross.

As a result of the survey, roughly three out of every five adults in Yolo County were X-rayed. There were 17,000 chest films taken and 8,000 blood sugar examinations done. The results of follow-up examinations are not entirely complete but little change is expected. At this point, the picture looks as follows:

19 patients with active pulmonary tuberculosis were discovered during the survey. 15 of those had been previously unknown, 4 of them had a history of tuberculosis but were believed to be inactive and were no longer under treatment.

29 persons were found to have diabetes in need of treatment, 26 of those had no previous knowledge, 3 of them suspected that they were diabetics but were not under treatment.

22 persons were found to have heart disease and were referred to their physicians. Only 2 of those had no previous knowledge of their illness. The others were already under treatment or needed no treatment at the time.

5 malignant lung tumors were found, 3 previously unknown, 2 previously known.

There were 16 persons found to have other chest diseases, such as coccidioidomycosis, bronchiectasis, and others. Of those, 9 were unaware of their illness and 7 had previously been under treatment.

It should be stated that the tuberculosis findings are somewhat more than the expected average. On a nationwide scale about 1 in 1,000 persons X-rayed is found to have active tuberculosis. This goes up to about 1.5 in densely populated areas and down to .5 per 1,000 in rural areas like Yolo County. In view of this fact, the discovery of 19 persons with active tuberculosis among 17,000 X-rayed must be considered high.

Follow-up examinations have been eminently successful and the cooperation of both physicians and patients has been splendid. All patients have immediately been placed under care and there has been no delay in securing hospitalization.

The cost of the survey, in addition to equipment and services of personnel supplied by the United States Public Health Service, the State Department of Public Health, and the State Tuberculosis and Health Assoc-

iation, has been somewhat less than \$5,000. Of this sum the health department contributed \$2,500, the Bureau of Chronic Diseases of the California State Health Department, \$1,500 (this amount mainly covered the expenses for the diabetes part of the survey), and the Yolo County Tuberculosis and Health Association. Since 25,000 examinations were done for \$5,000, this amounts to 20 cents per examination, which in a recent nation-wide survey was found to be the irreducible minimum. Of those 20 cents, the health department spent one dime and the other dime came jointly from the Yolo County Tuberculosis and Health Association and the State Health Department.

The reason for this low cost is the fact that most services on the local level were rendered on a voluntary basis by active community participation. Thus, the cost of personnel and equipment in addition to that donated by federal, state and local agencies, was minimal. The services of two health educators, one from the Bureau of Health Education of the State Department of Public Health, and one from the State Tuberculosis and Health Association, as well as consultants from the State Bureau of Public Health Nursing and the Bureau of Tuberculosis Control, were of incalculable value.

The immediate benefits of the survey are greater awareness of the tuberculosis and diabetes problem in Yolo County, better utilization of existing facilities, more cooperation between interested agencies, and routine X-raying of certain occupational groups, such as teachers and food handlers. Another bonus of the survey is the routine X-raying of prisoners.

As future policy it would seem advisable for the health department to see to it that all contacts of newly discovered tuberculosis patients are referred for follow-up examination, and for the Tuberculosis and Health Association through spot surveys to try to X-ray those two out of five who were not included in the survey this time.

Our common eventual goal, of course, is not only control but eradication of tuberculosis.

In our shrunken world, health, like peace and security, is indivisible and mankind's fight against illness, its major enemy, can be won only through concerted efforts of us all.—Dr. Brock Chisholm

Public Health Positions

Butte County

Director of Nurses: The Butte County Health Department will have a vacancy in the Director of Public Health Nursing position on or before December 1, 1953. The department offers a general program, including school nursing in a semirural area of 65,000, with a budgeted staff of 20, 6 of whom are public health nurses, and a clinic nurse.

The salary is \$391 to \$486 per month, with membership in the State Retirement Fund, and vacation and sick leave privileges. Transportation is furnished.

For further information address Richard C. Murphy, M.D., Director of Public Health, 2430 Bird St., Oroville.

Contra Costa County

Health Educator: This is a new position with the Contra Costa County Health Department. Salary \$429-\$515. Final filing date, October 23d. Applicants must have a master's degree in public health with major in health education. For further information write Contra Costa Civil Service Commission, Martinez.

Occupational Therapist and Physical Therapist: Applications will be received until positions are filled. No final filing date is set. Salary for both positions is \$341-\$410. Occupational therapist position requires registration or eligibility for registration with the National Registry of Qualified Occupational Therapists. Physical therapist position requires graduation from a recognized school of physical therapy.

Kings County

Public Health Nurse: Applicants must hold PHN degree. Starting salary, \$328. Car is furnished. Contact Donald Williams, M.D., Health Officer, Hanford, Cal.

Long Beach

Public Health Analyst: Applications must be filed in person by October 14th. Date of examination, October 20th. Salary range, \$333-\$405. Applicants must be graduates of college or university of recognized standing, with major in public health, statistics, or the social sciences. Completion of courses in statistics specified. Write to L. D. Litwack, M.D., Health Officer, City of Long Beach, 2655 Pine Ave., Long Beach.

State Department of Public Health

Physical Therapist for Physically Handicapped Children: Final filing date October 20th. Examination date November 10th. Salary range \$341-\$415. Applicants must have one year of supervised experience in physical therapy following graduation from a recognized school of physical therapy. California residence is not required. For further information inquire at closest office of State Personnel Board or State Department of Employment.

Public Health Medical Officer I, and II: Final date for filing, October 9th. Examination date, October 31st. Salary range for I, \$584-\$710. Salary range for II, range A, \$644-\$782; range B, \$676-\$821; range C, \$745-\$905. (Range depends on professional qualifications.)

A partial answer to the perplexing question of what has happened to the population of the State since the last federal census is given in a recent publication released by the State Department of Finance. This report, titled "Estimated Population of California, 1950-1953 with Population Projections to 1955," was prepared by Carl M. Friesen, Ph.D. It is one of a series of such population studies made by the Department of Finance that are of vital interest to state and local agencies that have the responsibility of providing services to the people of California, for one of the first considerations is obviously the number of people to be served.

Review of Reported Communicable Diseases Morbidity August, 1953

Diseases With Incidence Exceeding Five-year Median

Diseases	Aug., 1953	Aug., 1952	Aug., 1951	5-year medias
Chickenpox	515	394	629	457
Food poisoning	74	29	47	29
German measles	281	191	193	183
Hepatitis, infectious	102	46	21	21
Malaria	15	33	5	5
Measles	1,177	588	862	588
Meningitis	31	29	22	22
Mumps	994	775	611	777
Poliomyelitis	670	459	561	544
Rabies, animal	17	9	2	15
Salmonella infections	62	50	129	40
Shigella infections	104	53	74	69

Diseases Below the Five-year Median

Amebiasis	18	41	41	36
Brucellosis	5	8	7	8
Diphtheria	6	4	11	12
Influenza	8	13	26	19
Pertussis	118	327	326	327
Streptococcal infections, Respiratory, including				
Scarlet Fever	116	137	219	130
Tetanus	4	3	3	5
Typhoid Fever	10	12	15	14

Venereal Diseases

Syphilis	454	523	799	925
Gonococcal infections	1,226	1,342	1,766	1,801
Chancroid	8	13	16	1
Granuloma Inguinale	-	-	4	1
Lymphogranuloma venereum	7	3	6	1

¹ Median not calculated.

Special Census Releases

Series P-25. Estimates of the Population of States, July 1, 1940 to 1949 (72); Estimates of the Population of the United States by Age, Color and Sex, July 1, 1950, 1951 and 1952 (73); Provisional Estimates of the Population of the United States, January 1, 1950 to May 1, 1953 (74), January 1, 1950 to June 1, 1953 (75), January 1, 1950 to July 1, 1953 (77); Illustrative Projections of the Population of the United States by Age, Sex, 1955-1975 (78). **Series P-20.** School Enrollment, October, 1952 (43). **Series P-60.** Family Income in the United States, 1951 (12).

Copies of these releases may be obtained from: Library, Bureau of Foreign and Domestic Commerce, U. S. Department of Commerce at 315 Flood Building, 870 Market Street, San Francisco, California, or at 502 Rives-Strong Building, 112 West Ninth Street, Los Angeles, California.

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